

## California Child Health and Disability Prevention (CHDP) Program CHDP LABORATORY PROVIDER APPLICATION

**IMPORTANT:**

- Refer to attached instructions to complete this form.
- Type or print legibly.
- If a **clinical laboratory**, return completed form to your local CHDP Program.
- If a **blood lead laboratory**, return to:  
Children's Medical Services Branch  
Provider Services Unit  
P.O. Box 942732  
Sacramento, CA 94234-7320

### For Local CHDP Program Use Only

CHDP Program

Address (number, street)

City

County

State  
CA

ZIP code

**Application for participation as (check one):**

(Please see instructions for description.)

☐ Clinical laboratory☐ Blood lead laboratory

1. Legal name of laboratory	3. Medi-Cal provider number(s)	4. State laboratory license/registration number
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2. Business name if different from legal name
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5. Business address (laboratory location) (See instructions, <b>NOTE</b> )				
Number, street	City	County	State	ZIP code

6. Business telephone number (       )	7. Fax number (       )	8. E-mail address
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9. Pay-to name (last)                      (first)                      (middle initial)	10. Is the pay-to name a DBA name? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Federal tax ID number/federal provider number ( <i>attach copy</i> )
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12. Pay-to address			
Number, street	City	State	ZIP code

13. Type of business ( <i>check one</i> ):				
<input type="checkbox"/> Sole practitioner	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited liability corporation	<input type="checkbox"/> Other: _____ <span style="font-size: small;">(<i>please specify</i>)</span>

Principal owners

14. Director(s) of laboratory	
Name	Address
Name	Address

15. CLIA certificate number ( <i>attach copy</i> )	16. Certificate expiration date	17. Number of testing sites for this CLIA number
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18. Is this facility in a licensed acute care hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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### For LOCAL CHDP PROGRAM Use Only

Reviewed by CHDP Director (print name)	Signature	Date signed	Date CHDP Provider Data Sheet (PM 177) sent to State

The laboratory applicant hereby agrees to abide by the regulatory requirements and policies of the CHDP Program. The information submitted on this application and any attachments are true, accurate, and complete to the best of the Laboratory Applicant's knowledge and belief and are furnished in good faith. The Laboratory Applicant understands failure to comply with the requirements of the CHDP Program may result in disenrollment.

19. Printed name of Laboratory Director	(first)	(middle initial)	(last)
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20. Laboratory Director signature <b>IN BLUE INK ONLY</b>	Date
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21. Printed name of Owner	(first)	(middle initial)	(last)
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22. Owner signature <b>IN BLUE INK ONLY</b>	Date
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**Privacy Statement (as required by Civil Code, Section 1798 et seq.)**

All information requested on the application is required by the Department of Health Services (DHS) by the authority of Title 17, Section 6860. The consequences of not supplying the requested information are denial of enrollment as a CHDP provider and no issuance of the provider number to obtain reimbursement from the CHDP Program. Any information provided will be used to verify eligibility to participate as a provider in the CHDP Program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by the DHS, contact the Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

## INSTRUCTIONS FOR COMPLETION OF THE CHDP LABORATORY PROVIDER APPLICATION

**For assistance in completing this application, please call the local CHDP Program.  
Phone numbers can be found at [www.dhs.ca.gov/chdp](http://www.dhs.ca.gov/chdp).**

Laboratory providers wishing to enroll as a provider with the CHDP Program must complete an application packet and be approved by the local CHDP Program in order to bill the CHDP Program for CHDP services.

Upon review and approval of the completed application, the applicant will be assigned a provider number to use when billing the CHDP Program. Omission of any information or documentation on this application or the failure to sign this application may result in delays in processing or inability to process this application. Applicants may be contacted orally or in writing if additional information and documentation are needed. A separate application must be completed for each location you wish to provide CHDP services.

**Application for participation as:** Mark the box appropriate for the type of laboratory you are applying. A Clinical Laboratory is Clinical Laboratory Improvement Amendment (CLIA) certified by the State Laboratory Field Services Branch for all laboratory services except blood lead analysis. A Blood Lead Laboratory has been CLIA certified and qualified by the California Blood Lead Proficiency Assurance Program of the Environmental Health Laboratory Branch of the California State Department of Health Services for lead laboratory services.

1. Legal name of laboratory means the name under which the applicant is applying for a CHDP provider number and listed with the IRS.
2. Business name means the name of the laboratory applicant if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the record/stamped Fictitious Business Name Statement/Permit to the application.
3. Medi-Cal provider number(s): Provide all active Medi-Cal provider numbers of the applicant. Provide only the active Medi-Cal provider numbers that are assigned to the address indicated on this form.
4. State laboratory license/registration number: Provide the registration number and a copy of the license/registration.
5. Business address (location/site of laboratory) means the location where the applicant is providing services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit ZIP code. A post office box or commercial box is **not** acceptable. **NOTE:** Applicants with multiple business addresses must complete a separate application for each business address.
6. Business telephone number means the primary business telephone number used at the applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is **not** acceptable as the business telephone number.
7. Fax number means the facsimile number used at this business address.
8. E-mail address means the address to which electronic communications may be sent.
9. Pay-to name means the name of the person or business to which payment should be issued by the CHDP Program for CHDP services provided by the laboratory. The pay-to name may be the legal name indicated in number 1, or another person or business chosen by the applicant. **NOTE:** See number 1.
10. Indicate yes or no if the pay-to name is a "doing business as" (DBA) name. If yes, the DBA name will be the name in which payment will be issued by the CHDP Program.
11. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the Laboratory Applicant. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363. If the business is a Sole Proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN, if applicable.
12. The pay-to address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit ZIP code.
13. Indicate the type of business that applies to your business structure. Provide the names of the principal owners.
14. Enter the name(s) of the director(s) of the laboratory and the address where contact can be made.
15. Provide the current CLIA certificate number and attach a copy of the certificate to the application.
16. Enter the expiration date of the CLIA certificate.
17. Enter the number of testing sites to which the CLIA certificate applies.

18. Mark the appropriate box indicating whether or not this lab is located in a licensed acute care hospital.
19. Print the first name, middle initial, and last name of the Laboratory Director.
20. Laboratory Director signature means the first name, middle name, and last name of the Laboratory Director. An original signature **IN BLUE INK ONLY** is required. Indicate the date the application is signed. NOTE: Laboratory Director signature on the CHDP Laboratory Provider Program Agreement (DHS 4503) means the name and signature of the Laboratory Director indicated in number 19.
21. Print the first name, middle initial, and last name of the Laboratory Owner.
22. Laboratory Owner signature means the first name, middle initial, and last name of the Laboratory Owner. An original signature **IN BLUE INK ONLY** is required. Indicate the date the application is signed. NOTE: Laboratory Owner signature on the CHDP Laboratory Provider Program Agreement (DHS 4503) means the name and signature of the Laboratory Owner indicated in number 21.

**Did you remember to enclose (as applicable):**

- ☐ The original, signed CHDP Laboratory Provider Program Agreement (DHS 4503)
- ☐ Copy of FEIN or ITIN verification or social security card, if applicable
- ☐ Copy of Fictitious Business Name Statement/Permit, if applicable
- ☐ Copy of CLIA certificate
- ☐ Copy of laboratory license/registration
- ☐ Other, if applicable

If a **clinical laboratory**, send completed form to your local CHDP Program. If not indicated on page 1, mailing addresses may be found at **[www.dhs.ca.gov/chdp](http://www.dhs.ca.gov/chdp)**.

If a **blood lead laboratory**, send completed form to:

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